DPH Georgia Department of Public Health CHILDREN'S MEDICAL SERVICES

got transition

Medical Summary and Emergency Care Plan

Six Core Elements of Health Care Transition 2.0

This document should be shared with and carried by the patient.	
Date Completed:	Date Revised:
Form Completed By:	
Contact Information	
Name:	Nickname:
DOB:	Preferred Language:
Parent (Caregiver):	Relationship:
Address:	
Cell #: Home #:	Best Time to Reach:
E-Mail:	Best Way to Reach: Text Phone Email
Health Insurance/Plan:	Group and ID #:

Emergency Care Plan		
Emergency Contact:	Relationship:	Phone:
Preferred Emergency Care Location:		

Common Emergent Presenting Problems	Suggested Tests	Treatment Considerations

Special Concerns for Disaster:

Allergies and Procedures to be Avoided	
Allergies	Reactions
To be avoided	Why?
Medical Procedures:	
Medications:	

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Diagnoses and Current Problems	
Problem	Details and Recommendations
Primary Diagnosis	
Secondary Diagnosis	
Behavioral	
Communication	
Feed & Swallowing	
Hearing/Vision	
Learning	
Orthopedic/Musculoskeletal	
Physical Anomalies	
Respiratory	
Sensory	
Stamina/Fatigue	
Other	

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Medications					
Medications	Dose	Frequency	Medications	Dose	Frequency

Health Care Providers				
Provider	Primary and Specialty	Clinic or Hospital	Phone	Fax

Prior Surgeries, Procedures, and Hospitalizations	
Date	
Date	
Date	
Date	
Date	

Baseline		
Baseline Vital Signs: RR	HR	BP
Height:	Weight:	Blood Type:
Baseline Neurological Status:		

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Most Recent Labs and Radiology

Test	Date	Result
EEG		
EKG		
X-Ray		
C-Spine		
MRI/CT		
Other		

Equipment, Appliances, and Assistive Technology

Gastrostomy	☐	☐	Adaptive Seating	☐	☐	Wheelchair		
Tracheostomy	☐	☐	Communication Device	☐	☐	Orthotics		
Suctions	Monitors:			☐	☐	Crutches		
Nebulizer	☐	☐	Apnea	☐	☐	O2	☐	☐ Walker
	☐	☐	Cardiac	☐	☐	Glucose		

Other

School and Community Information

Agency/School	Contact Information
	Contact Person: Phone:

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	Contact Person:	Phone:
	Contact Person:	Phone:

Special information that the patient wants health care professionals to know

Patient signature	Print Name	Phone Number	Date
Parent/Caregiver	Print Name	Phone Number	Date
Primary Care Provider Signature	Print Name	Phone Number	Date
Care Coordinator Signature	Print Name	Phone Number	Date

Please attach the immunization record to this form.